

New/Changed Dose

Cancer – Hematologic | Cyclophosphamide, Gleevec®, Gleostine®, Ninlaro®, Onureg®, Rydapt®, Sprycel®, Tabloid®, Targretin®, Tasigna®, Zolinza®

Prescriber Information

Prescriber Name MD DO NP PA NPI Office Contact Practice Name / Collaborating MD Address City State Zip Phone Fax

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name Last 4 Digits of SS# DOB Sex M F Weight Height Diabetic? Y N Address City State Zip Home Phone Work/Cell HIPAA Contact Emergency # Interpreter Needed? Y N Allergies Y N If Yes, list allergies

Insurance Information

Primary Insurance Policy ID Group# BIN PCN Policyholder Name Policyholder DOB

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10 Code Weight lb kg Height in cm BSA m2 Diagnosis Date Current SCr or current GFR ml/min Confirmation Mutations Prior Therapy Reason for Discontinuation of Therapy Approximate Start Date Approximate End Date

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
CYCLOPHOSPHAMIDE	25 mg capsule 50 mg capsule			
GLEEVEC® (imatinib)	100 mg tablet 400 mg tablet	Take ____ mg by mouth ____ times a day Other: _____		
GLEOSTINE® (lomustine)	40 mg capsule			
NINLARO® (ixazomib)	4 mg capsule	Take 4 mg (1 capsule) by mouth once daily on days 1, 8 and 15 of a 28 day cycle without food (at least 1 hour before or 2 hours after a meal) Other: _____		
ONUREG® (azacitidine)	200 mg tablet 300 mg tablet	Take 300 mg (1 tablet) by mouth once daily on days 1-14 of each 28-day cycle Other: _____		
RYDAPT® (midostaurin)	25 mg capsule	Take ____ mg by mouth two times a day with food Other: _____		
SPRYCEL® (dasatinib)	20 mg tablet 50 mg tablet 70 mg tablet 80 mg tablet 100 mg tablet 140 mg tablet	Take ____ mg by mouth once daily Other: _____		
TABLOID® (thioguanine)	40 mg tablet			
TARGRETIN® (bexarotene)	75 mg capsule	Take ____ mg by mouth once daily with a meal Other: _____		
TASIGNA® (nilotinib)	50 mg capsule 150 mg capsule 200 mg capsule	Take ____ mg by mouth two times daily Other: _____		
ZOLINZA® (vorinostat)	100 mg capsule	Take ____ mg by mouth once daily with food Other: _____		

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____

Prescriber Signature _____

Date _____ *Substitution Permitted*

Date _____ *Dispense as Written*

If brand is required, please write
"DAW" in the box to the right.